Agency Code	Subagency Code

Public Employees Benefits Board

Long Term Disability Evidence of Insurability Form

- Type or print clearly in ink.
- Return this form to your employer.

NOTE: Inaccurate, incomplete, or illegible information may delay your coverage.

Note: If you do not want this evidence of insurability to go through your employer, send this form directly to Standard Insurance Company, Attn. Medical Underwriting Dept., 900 SW 5th, Portland, OR 97204-1235.

Social Security Number	Last Name	First Name	Middle Initial	Phone: Work ( ) Home ( )

Agency Name and Division

Complete this section ONLY if you are applying for optional benefits more than 31 days after the date you entered an eligible classification or if decreasing the optional waiting period. Read the Information Practices Notice on the back of this form before completing the questionnaire.

1. Height _____ Weight _____

   Occupation _____

   Birthplace _____

2. Have you ever been declined for insurance by any company or fraternal order, or has any such company or order declined to issue a policy as applied for or declined to reinstate a policy? ☐ Yes ☐ No
3. Have you had any physical, mental, or emotional condition, injury, or sickness in the past five years? ☐ Yes ☐ No
4. Have you consulted or been prescribed for or attended by a physician or practitioner for any cause in the past five years? ☐ Yes ☐ No
5. Have you ever been treated for or had any known indication of the following:
   a. High blood pressure, heart disease, arteriosclerosis, or any problem with the back or spine? ☐ Yes ☐ No
   b. Stroke, epilepsy, depression, mental illness, cancer, diabetes, or nephritis? ☐ Yes ☐ No
   c. Lung, kidney, stomach, or intestinal trouble? ☐ Yes ☐ No
   d. Blindness or deafness? ☐ Yes ☐ No
   e. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
6. Are you now unable to work full time because of any physical, mental, or emotional condition, injury, or sickness? ☐ Yes ☐ No
7. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years? ☐ Yes ☐ No
8. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, or skin lesions? ☐ Yes ☐ No
9. Do you take regular medication for the treatment or control of any physical, mental, or emotional condition, injury, or sickness? ☐ Yes ☐ No
10. Do you contemplate any operation or visit to a doctor or practitioner for an existing physical, mental, or emotional condition, injury, or sickness? ☐ Yes ☐ No
11. Are you now pregnant? ☐ Yes ☐ No

Please provide details in connection with any question answered "yes" above. Give FULL details below including names of physicians, hospitals, illnesses, number of attacks, and other pertinent information. (Enclose separate sheet if more space is required.)

Question Number	Give Complete Description of Injuries, Disorders, and Operations	Month and Year	Duration	Final Result	Names and Addresses of Physicians and Clinics Consulted

I hereby declare that the statements contained herein are true and complete, and I understand that they form the basis of any coverage under the group policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescinding my insurance and/or denial of payment of a claim. I acknowledge that I have read the Information Practices Notice and that I have kept a copy of this *Evidence of Insurability Form* and the Information Practices Notice. I further acknowledge and agree that the insurance does not become effective until the first of the month after this application is approved by Standard Insurance Company, subject to the Active Work requirement. In the meantime, I agree that Standard Insurance Company's liability is limited to the return of any premium which may have been paid.

To any physician, health care provider, hospital, insurance company, the Medical Information Bureau, Inc., or my employer: I authorize you to release to Standard Insurance Company all medical information you have about me including medical history, diagnosis, prognosis, and treatment of any physical or mental condition. I understand that the information obtained will be used to determine my eligibility for group insurance coverage. I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Signed: _____ Date: _____

For Agency Use
Date sent to carrier:

_____
Date / Initials

Information Practices Notice

To help us determine your eligibility for group insurance, we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or Medical Information Bureau, Inc. (MIB). We will use the authorization you signed on the front side of this form when we seek this information.

MIB information that we collect about you is confidential. However, Standard Insurance Company may make a brief report to the MIB. MIB is a nonprofit corporation. It exchanges information among its member life insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or if you submit a claim for benefits to such a member company, MIB will supply the member company with any information it has about you in its files. This will be done only upon the member company's request. Standard may also release information about you to other insurance companies to whom you have applied for life or health insurance or made a claim for benefits.

MIB will disclose any information it has about you at your request. However, medical information will be released only to your attending physician. If you believe that the information MIB has about you is incorrect, you may contact MIB and request a correction. Your request for correction will be handled by MIB in accordance with the procedures outlined in the federal Fair Credit Reporting Act. The address of the MIB information office is:
160 University Avenue, Westwood, Massachusetts 02091. MIB's telephone number is 781-329-4500.

DISCLOSURE TO OTHERS—The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.

DISCLOSURE TO OTHERS—You have a right to know what we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, please write to us.

Group Medical Underwriting Department, G-18
Standard Insurance Company
P.O. Box 711
Portland, OR 97207

PLEASE RETAIN A COPY OF THIS NOTICE FOR YOUR RECORDS.